STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION OO			(X3) DATE SURVEY COMPLETED	
		155697	A. BUILD B. WING	ING		11/14/	2012
NAME OF I	PROVIDER OR SUPPLIE	D D		STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		AND SKILLED NURSING CENTE			ITTLE LEAGUE BLVD SVILLE, IN 47129		
			K		5VILLE, IN 47 129		975)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	PI	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
F0000							
	This visit was for	or Investigation of	F000	n			
This visit was for Investigation of Complaint IN00118464.		17000					
		3110101.					
	Complaint IN00	0118464 - Substantiated.					
	Federal/state de	eficiencies related to the					
	allegations are o	cited at F309 and F314.					
	II	t					
	Unrelated defici	iency cited.					
	Survey dates: November 13 and 14, 2012						
	Facility number	:: 000059					
	Provider numbe						
	AIM number: 1	100266560					
	Survey team: Jo	ennie Bartelt, RN					
	Census bed type	e:					
	SNF: 6						
	SNF/NF: 63						
	Total: 69						
	Census payor ty	ine:					
	Medicare: 12	rpe.					
	Medicaid: 53						
	Other: 4						
	Total: 69						
	Sample: 3						
		ties reflect state findings ance with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000059

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2012 FORM APPROVED OMB NO. 0938-0391

155697 B. WING	A. BUILDING B. WING					
NAME OF PROVIDER OR SUPPLIER 517 N LITT CLARK REHABILITATION AND SKILLED NURSING CENTER CLARKSV	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE				
Quality review completed on November 16, 2012 by Bev Faulkner, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2GDM11

Facility ID: 000059

If continuation sheet

Page 2 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		A. BUILDING 00		(X3) DATE S COMPLI 11/14/2	ETED		
	PROVIDER OR SUPPLIER	L AND SKILLED NURSING CENTER	B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0309 SS=D	HIGHEST WELL Each resident mu must provide the services to attain practicable physic psychosocial wel the comprehensic care. Based on record facility failed to	necessary care and or maintain the highest cal, mental, and l-being, in accordance with we assessment and plan of review and interview, the ensure the resident with	F03	09	What corrective action(s) wil be accomplished for those residents found to have beer		11/28/2012
	diarrhea was ass planning and im- needed for 1 of 1 related to compl	usea, vomiting, and essed consistently for plementing care as I resident reviewed aints of nausea, vomiting, a sample of 3. (Resident			affected by the deficient practice?Resident C was discharged to home How oth residents having the potentiato be affected by the same deficient practice will be identified and what correctiv action(s) will be taken?All residents have the potential be affected by the alleged	er al	
	reviewed on 11/ record indicated	ord for Resident C was 13/12 at 12:00 p.m. The the resident was admitted 9/16/12 following total at.		deficient practice.Review completed of residents and 1 resident did complain of loose stools and was added to hot charting for abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of		se of	
	from 9/16/12 unindicate the residual vomiting, or diamondate. Progress Notes, a.m., indicated, '				mental status. Licensed nurs will be in-serviced by SDC/designee 11/27/2012 on assessing residents with diarrhea to include vital sign abdominal evaluation, description of bowel movem, severity, signs of possible fluid volume depletion and a change in mental status. Any	s, ent ny	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2GDM11

Facility ID: 000059

If continuation sheet Page 3 of 23

NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER CLARK REHABILITATION AND SKILLED NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intact. Continues ABT [antibiotic] r/t [related to] knee infection per MD order. No ADR [adverse drug reaction] noted. C/O [complains of] n/v/d [nausea, vomitting, diarrhea. PRN [as needed] Phenergan [anti-emetic] suppository given per MD order. Effective. Will call MD for order r/t diarrhea. Call light within reach." Documentation in Progress Notes and in Vitals Results failed to indicate an assessment of the resident including vital signs, description of the emesis and diarrhea, observation of the abdomen, auscultation for bowel sounds, palpation of the abdomen, and indication of pain. Vitals Results on 9/28/12 at 7:07 a.m., indicated 99.0 degrees Fahrenheit. No other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrhea]] P.O. [by mouth] now. 65 mg acetaingneham	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		f '			(X3) DATE S	URVEY	
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failed to indicate an assessment of the resident including vital signs, description of the emesis and diarrhea including number of episodes and character of the emesis and diarrhea, observation of the abdomen, auscultation for bowel sounds, palpation of the abdomen, and indication of pain. Vitals Results on 9/28/12 at 7:07 a.m., indicated 99.0 degrees Fahrenheit. No other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by further education including disciplinary action.DNS/designee is responsible to ensure compliance.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Review completed of residents and 1 resident did complain of loose stools and was added to hot charting for abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs,						·	ith	
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resident including vital signs, description of the emesis and diarrhea including number of episodes and character of the emesis and diarrhea, observation of the abdomen, auscultation for bowel sounds, palpation of the abdomen, and indication of pain. Vitals Results on 9/28/12 at 7:07 a.m., indicated 99.0 degrees Fahrenheit. No other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by is responsible to ensure compliance. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Review completed of residents and 1 resident did complain of loose stools and was added to hot charting for abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs,		failed to indicate	e an assessment of the			,	100	
of the emesis and diarrhea including number of episodes and character of the emesis and diarrhea, observation of the abdomen, auscultation for bowel sounds, palpation of the abdomen, and indication of pain. Vitals Results on 9/28/12 at 7:07 a.m., indicated 99.0 degrees Fahrenheit. No other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by compliance.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Review completed of residents and 1 resident did complain of loose stools and was added to hot charting for abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs,		resident includir	ng vital signs, description					
number of episodes and character of the emesis and diarrhea, observation of the abdomen, auscultation for bowel sounds, palpation of the abdomen, and indication of pain. Vitals Results on 9/28/12 at 7:07 a.m., indicated 99.0 degrees Fahrenheit. No other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Review completed of residents and 1 resident did complain of loose stools and was added to hot charting for abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs,							/ill	
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palpation of the abdomen, and indication of pain. Vitals Results on 9/28/12 at 7:07 a.m., indicated 99.0 degrees Fahrenheit. No other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by			·					
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abdominal evaluation, description of stool, severity, fluid volume depletion and if any change of mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs,								
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other vital signs were indicated. A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs,		indicated 99.0 de	egrees Fahrenheit. No					
A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by mg Immodium [ant		other vital signs	were indicated.			_		
A Nursing Progress Note on 9/28/12 at 7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by mental status. Licensed nurses will be in-serviced on assessing residents with diarrhea to include vital signs,						_	of	
7:22 a.m., indicated, "N.O. [new order] 4 mg Immodium [anti-diarrheal] P.O. [by diarrhea to include vital signs,		A Nursing Progr	ress Note on 9/28/12 at					
mg Immodium [anti-diarrheal] P.O. [by diarrhea to include vital signs,						will be in-serviced on		
diarrilea to include vital signs,		·				_		
I mount now not magacetaminonnen						_	s,	
a a a a a a a a a a a a a a a a a a a		mouth] now. 650 mg acetaminophen				abdominal evaluation,		
		[pain/temperature medication] suppository q [every] 4 hours prn [as needed]. Stool sample for C-diff [Clostridium difficile - bacteria causing diarrhea] stat [immediately] CBC				_	ent	
fluid colours doubtless and acco							,,,	
I change in mental status Δn_V I							-	
[Clostridium difficile - bacteria causing resident identified during the								
diarrhea] stat [immediately] CBC clinical meeting with loose stools							ols	
[complete blood count] and BMP [basic will be added to daily charting to		, ,	• -			_		
metabolic profile]." assess every shift including vital		- 1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2GDM11

Facility ID: 000059

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DDIC	00	COMPL	ETED
		155697	A. BUII B. WIN			11/14/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	R			ITTLE LEAGUE BLVD		
CLARKE	PEHARII ITATION A	AND SKILLED NURSING CENTER			SVILLE, IN 47129		
					OVILLE, IIV 47 123		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	•		DATE
					signs, abdominal evaluation, description, fluid volume deple	tion	
	A Physician Tel	ephone Order, dated			and mental status changes. Pl		
	9/28/12 at 7:20 a	n.m., indicated, "4 mg			of care will also be updated, w		
	Immodium p.o. now, 650 mg				MD/family		
	acetaminophen suppository q 4 [symbol				notification.Non-compliance w	ith	
	for hours] PRN, C-dif [sic] (before				these practices will result in		
	suppository), Stat CBC & BMP" The Care Plan Update section of the				further education including		
					disciplinary action.DNS/desigr is responsible to ensure	iee	
	•	phone Order indicated,			compliance. How the correcti	VΑ	
		•			action(s) will be maintained t		
		D T [temperature] - 99			ensure the deficient practice		
		Stop N/V/D and to bring			will not recur, i.e., what quali	ty	
	•	IL [within normal limits].			assurance program will be p	ut	
	The intervention	s were the same as the			into place?The CQI audit for		
	physician's order	rs.			change of condition will be		
					utilized weekly x4, monthly x		
	The Medication	Administration Record			and quarterly thereafterFinding	ngs	
	for September 20	012 indicated no			from the CQI process will be reviewed monthly a nd an action	on	
	acetaminophen s				plan will be implemented as	JII	
	administered.	A Procession			needed for any deficient practi	ces	
	dammingtered.				below 95% threshold.The		
	The next records	ed Vital Signs were on			DNS/designee is responsible		
		o.m., and the next Nursing			to ensure compliance		
		,					
		as 9/28/12 at 6:07 p.m.					
	_	ogress Note indicated,					
		vo episodes of loose					
	stools and no c/o	nausea or vomiting. Lab					
	results received	indicating elevated WBC					
	[white blood cou	int]. New orders received					
	to administer Ro	ocephin [antibiotic] IM					
		njection] now, to obtain					
	-	J - /					
	stool sample for C-diff culture [second order received for this test], to obtain U/A						
		_					
		C&S [culture and					
	sensitivity, to o	btain chest x-ray to r/o	1				

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Event ID: 2GDM11

Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 11/14/	ETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE	1	
		ND SKILLED NURSING CENTER	<u>. </u>	l	SVILLE, IN 47129		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[antibiotic used idiarrhea] 500mg hours] X 10 days precautions until received. Stool, collected with lackest x-ray order to be in facility well and denies produced an	te. Resident tolerated pain or soreness to Documentation failed to sment of diarrhea or of episodes and diarrhea, observation of scultation for bowel on of the abdomen, and n. g Progress Note was p.m., and indicated, emperature ted Flagyl contact precautions est results." Cailed to indicate an					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2GDM11

Facility ID: 000059

If continuation sheet

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		155697	B. WING			11/14/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
			_		ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTE	K	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		r distress alert and		IAG			DATE
	*	rson, place, time] makes					
		bowel sounds are active					
	X 4 quads [abdox						
		and nontender assisted					
		ties of daily living] X 1					
	_	en needed call light					
	within reach."	ion nooded out tight					
	Vital Signs were	documented on 9/29/12					
	at 1:46 a.m.	40 Valinomou on 37 237 12					
	The next Nursing	g Progress Note was on					
	· ·	o.m., and indicated,					
	_	lagyl r/t diarrhea and in					
		r/t poss [possible] c-diff.					
	C/O loose stools						
	Documentation f	failed to indicate					
	monitoring of vi	tal signs or other					
	assessments rela	ted to the diarrhea.					
	No further Nursi	ng Progress Notes were					
	in the record unt	il the resident was					
	readmitted from	the hospital on 10/4/12.					
	_	appointment/Transfer -					
		Skilled Nursing Center					
		dent Transfer Form, dated					
		o.m., indicated, "Res has					
		28/12. C/O dizziness and					
		ly requests transfer to					
	=	ospital]VS [vital signs]					
	WNL [within no	rmal limits]."					

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Event ID: 2GDM11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN			11/14	/2012
NAME OF D	PROVIDER OR SUPPLIER	•	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUFFLIER				ITTLE LEAGUE BLVD		
		ND SKILLED NURSING CENTER	₹		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
		tory and Physical, dated					
		ed, "Chief Complaint: I					
	had nausea and vomiting and diarrhea						
		ominal cramping" and					
	· · · · · · · · · · · · · · · · · · ·	ent Illness: (Name)who					
	1	I believe at the Clark					
		r a rehabilitation process					
		tht total knee, which is					
	1	itShe developed some					
		nd fever with nausea,					
		ing, diarrhea, abdominal					
	distention, and c	ame into the emergency					
	room who [sic] v	was diagnosed with					
	colitis, C. diffici	le specifically and					
	diverticulitis"						
	During interview	y on 11/14/12 at 12:40					
	p.m., the Assista	nt Director of Nurses					
	(ADON) indicate	ed there were no other					
	assessments of th	he resident related to the					
	diarrhea. The A	DON indicated the					
		no problem with diarrhea					
		admission to the facility,					
	but the resident l	•					
	diverticulitis.						
	ar, or trouring.						
	Review of the di	agnoses lists on the					
		ian Orders for September					
	1	ospitalization on 9/29/12)					
	-	2012 (after readmission					
		`					
	l '	cated the diagnosis of					
		c diverticulitis was not					
	indicated until at	fter the hospitalization.					
			1				1

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Event ID: 2GDM11

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIJII	LDING	00	COMPL	ETED
		155697	B. WIN			11/14	/2012
	n overnon a	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	K			ITTLE LEAGUE BLVD		
	REHABILITATION A	AND SKILLED NURSING CENTE	R		SVILLE, IN 47129		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	v on 11/14/12 at 4:05					
		's Nurse Consultant and					
	the ADON indicated the facility had no						
	policy related to resident assessment for						
	diarrhea.						
		American Medical					
		ation's Know-it-all Before					
		Collection System" guides					
		l to Physical Data for					
		iarrhea: "Vital signs,					
	especially lying,	, sitting, and standing					
	blood pressure (if obtainable) and pulse;					
	Abdominal eval	uation, including presence					
	of abdominal pa	in, tenderness, distension,					
	guarding; Detail	led description of bowel					
	movements, incl	luding quantity,					
	frequency, consi	istency (loose, soft, water,					
		ontents (blood, pus,					
	· ·	there has been continuous					
		stool (paradoxical					
		m a digital rectal					
	, .	eck for pain, tenderness,					
		ce of hard, dry stool in the					
	-	ange in mental status,					
		behavior, or level of					
		Signs of possible fluid					
		n or dehydration (postural					
	•	tachycardia, rapid					
	-	-					
	_	cked lips, thirst, new onset					
	or increased con	itusion, fever)."					
	This foderal 4-	is related to Commission					
	_	is related to Complaint					
	IN00118464.						I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2GDM11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/14/2012
	PROVIDER OR SUPPLIE	R AND SKILLED NURSING CENTER	517 N L	ADDRESS, CITY, STATE, ZIP CODE LITTLE LEAGUE BLVD SVILLE, IN 47129	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NOT MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	3.1-37(a)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2GDM11

Facility ID: 000059

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING OO COMPLETE			ETED	
		155697	B. WIN			11/14/	2012
NAME OF I			_		ADDRESS, CITY, STATE, ZIP CODE	-	
NAME OF E	PROVIDER OR SUPPLIER	L		517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER	! 	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314 SS=D	PRESSURE SOF Based on the con a resident, the factor resident who enteressure sores do sores unless the condition demons unavoidable; and sores receives neservices to promoting to the facility failed to pressure ulcer for the facility without when the resident ulcer, the facility resident's nutritic fever, in accordant The deficient praces a sample of 3. (In Findings included the clinical record indicated from the hospital discharged to the The resident's calindicated the resident resident resident's calindicated the resident's calindicated the resident's calindicated the resident resident resident's calindicated the resident's calindicated the resident's calindicated the resident r	inprehensive assessment of cility must ensure that a pers the facility without ones not develop pressure individual's clinical strates that they were a resident having pressure pressure that they were a resident having pressure pressure that they were are sident having pressure pressure that they were are sident having pressure pressure that they were are sident who the healing, prevent went new sores from the prevent development of a pressure ulcer. In the developed a pressure of failed to monitor the ponal intake and check for the sident	F03	14	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident A no longeresides in the facility How otheresidents having the potentiat to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential be affected by the alleged deficient practice. All resident currently with alterations with skin integrity were reviewed ensure nutritional intake is monitored. Licensed nurses were inserviced on assessing residents skin upon admissionand weekly, nutritional intake and fevers by the wound nurse/designee on 11/27/201; post test included on or before C.n.a's were re-educated on checking and changeing residents, and	erer er	11/28/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 2GDM11

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPL	ETED
		155697		LDING		11/14/	2012
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
		AND OKULED AUTDOING OFFITEE			LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION	AND SKILLED NURSING CENTER	(CLARK	(SVILLE, IN 47129		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	incontinence, a	diagnosis of diabetes			turning/repositioning		
	mellitus, and an	emia			residents every 2 hours by the	ne	
	moments, and anoma.				wound nurse/designee on or	•	
	Progress Notes, dated 10/30/12 at 3:59				before 11/27/2012-post test		
					included.Any wounds identif		
		"This nurse is called into			on admission or weekly skin		
	resident's room	by cna [sic] to look at his			assessment will be measure	d,	
	coccyx area. U	pon observation this nurse			MD notified, treatment		
	observes that th	e whole coccyx area is			obtained, individual wound	_	
		r and on the right coccyx a			sheet completed, care plann		
	_	ea was measured 2 cm X 2			and added to the weekly NAI	₹	
					(Nutrition at Risk)review-to		
		th no drainage observed.			consist of nutritional intake		
	1	has a stage 1 area of dark			weights, skin, treatments, an	ıu	
	purple under the	e skin measuring 4 cm X 5			if wound has improved or declined by the wound		
	cm with skin in	tact. [The American			nurse/designee.Non-complia	nc	
	Medical Directo	ors Association Pressure			e with these practices will		
	Ulcers in the Lo	ong Term Care Setting			result in further education		
		e Guidelines indicates,			including disciplinary		
		· · · · · · · · · · · · · · · · · · ·			action.Wound nurse/designe	e	
		tissue injury: Purple or			is responsible to ensure		
		ed area of discolored intact			compliance. What measures		
		mage of underlying soft			will be put into place or what	t	
	tissue from pres	sure and/or shear"]			systemic changes will be ma	ıde	
	Area is cleaned	and an allevyn dressing is			to ensure that the deficient		
	applied to the ri	ght stage 2 and magic butt			practice does not recur? All		
	1 * *	I to the left buttock as			residents currently with		
		eport to adon [Assistant			alterations with skin integrity	/	
		-			were reviewed to ensure		
		sing] [name] for			nutritional intake is		
	appropriate trea	tment orders."			monitored. Licensed nurses		
					were inserviced on assessin	_	
	A Physician Orders/Nursing Orders, dated				residents skin upon admissi		
	10/30/12 at 7:00 a.m., indicated, "Cleanse				and weekly, nutritional intake and fevers by the wound	es	
	area to R [right] coccyx [with] normal				nurse/designee on 11/27/201	,	
	saline. Pat dry apply Santyl cream to				post test included on or before		
	1				C.n.a's were re-educated on		
		and cover [with] alleven			checking and changeing		
	[sic] every day.	" The Care Plan Update					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155697	B. WIN			11/14/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIEF	L			ITTLE LEAGUE BLVD	
CLARK F	REHABILITATION A	ND SKILLED NURSING CENTER			SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	section of the or	ders indicated, "Problem:			residents, and	
	Stage 1 & 2" and "Intervention: 1. Follow order above. 2. Call MD PRN [as needed] for follow up." Progress Notes, dated 10/31/12 at 5:54 p.m., created by the Dietary Manager,				turning/repositioning	
					residents every 2 hours by th	
					wound nurse/designee on or before 11/27/2012-post test	
					included.Any wounds identif	ied
					on admission or weekly skin	
					assessment will be measured	
					MD notified, treatment	
	indicated, "14 da	•			obtained, individual wound	
	10/26/12Current wt. [weight] is 148# [pounds], down 1# since admissionResident has two new Stg				sheet completed, care planne	ed
					and added to the weekly NAF	₹
					(Nutrition at Risk)review-to	
	[stage] II areas o	n coccyx. Will rec			consist of nutritional intake	
	[receive] a MVI	[multivitamin] with			weights, skin, treatments, an	d
	minerals to aid in	n healing and low			if wound has improved or	
		d Hct [hemoglobin and			declined by the wound nurse/designee.Non-complia	no
		ll cont [continue] to			e with these practices will	
	_	ts. [weights] and cont			result in further education	
					including disciplinary	
	[continue] with p	olan of care."			action.Wound nurse/designe	e
					is responsible to ensure	
	· ·	lated 10/31/12, indicated,			compliance. How the correct	ive
	"Problem: Resid	lent at risk for			action(s) will be maintained t	
	unintentional we	eight loss related to leaves			ensure the deficient practice	
	25% of some me	ealsResident has two			will not recur, i.e., what quali	·
	Stg II open areas	s on coccyx." Goal, with			assurance program will be po	ut
		22/13 indicated, "Resident			into place?The CQI audit for skin management will be	
	_	eight of 148# with no sig.			utilized weekly x4, monthly x	6
		nge. Resident will			and quarterly thereafter.findir	
					from the CQI process will be	J -
		of therapeutic diet thru			reviewed monthly and an action	on
	_	en areas will be healed."			plan will be implemented as	
		eluded, but were not			needed for any deficient prctic	
	-	onitor Food/Fluid intake			below the 95% threshold.Wou	nd
	at meals. Monit	or weight. Notify			nurse and DNS/designee is responsible to ensure	
	MD/family of si	gnificant weight			compliance.	
	changes"				compilarioo.	

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Event ID: 2GDM11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155697	B. WIN	G		11/14/	2012
NAME OF E	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			517 N L	ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The Skin Integri						
	[American Senion	or Communities] Pressure					
	Wound Skin Eva	aluation Report, dated					
	11/1/12, indicate	ed the resident's wound to					
	the right buttock	was not present on					
	admission, was a	a Stage 2 with the most					
	severe tissue typ	e of "Necrotic/eschar					
		r tan tissue adheres to					
		easured 2.0 cm X 1.5 cm					
	X 0.1 cm, with wound color of 70%						
	necrosis/30% beefy red, no drainage, no						
		dicated, "Resident has a					
		uttocks and a Stage 2 to					
	_	s. Area has a dark center					
	•						
	but no drainage						
		rple surrounding wound					
		uctional notation on the					
	_	"Stages of pressure					
		onsUnstageable -					
		s present (eschar/black) -					
		ssible until the eschar or					
	slough is remove	ed."					
	~	v on 11/14/12 at 4:05					
	p.m., the Assista	ant Director of Nursing					
	indicated the res	ident's right buttock					
	wound was class	sified as a Stage 2, instead					
	of an unstageabl	e wound with eschar,					
	since a portion of	of the wound bed was					
	visible and beefy						
	The Care Plan, o	lated 11/2/12, indicated,					
		npaired skin integrity:					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIIII	A. BUILDING			COMPLETED	
		155697	B. WIN			11/14	/2012	
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	.R		517 N L	ITTLE LEAGUE BLVD			
CLARK F	REHABILITATION	AND SKILLED NURSING CENTE	₹	CLARK	SVILLE, IN 47129			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		ittocks." The Goal, with						
	-	2/13, indicated, "Wound						
		n signs of complications						
		ext review." Interventions						
		ere not limited to,						
	_	esident to eat at least 75%						
	of mealsObse	rve for signs of infections:						
	fever"							
	The Vitals Resu	ılts for the resident's stay						
	at the facility in	dicated no documentation						
	related to food	intake from 10/31 to						
	11/7/12 on the	following dates for meals						
	as indicated: 10	/31/12: breakfast and						
	supper undocur	nented; 11/1/12: breakfast						
	and lunch undo	cumented; 11/2/12:						
		nented; 11/3/12: dinner						
		11/5/12: dinner						
		11/6/12: dinner						
		and 11/7/12: breakfast						
	· · · · · · · · · · · · · · · · · · ·	Documentation indicated						
		sumed none of the						
		s: lunch on 10/31/12 and						
		2. The resident's meal						
	consumption pe							
		less than 75% for the						
		s: dinner on 11/1/12;						
	_	unch on 11/2/12; dinner on						
		ast and lunch on 11/5/12;						
		ast and function 11/5/12, and lunch on 11/6/12.						
	and oreaktast at	ng ranch on 11/0/12.						
	_	w on 11/14/12 at 4:05						
		y's Nurse Consultant and						
	Assistant Direct	tor of Nursing (ADON)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155697	B. WIN			11/14/	2012
NAME OF P	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
		ND SKILLED NUDSING CENTED	517 N LITTLE LEAGUE BLVD R CLARKSVILLE, IN 47129				
		ND SKILLED NURSING CENTER			SVILLE, IN 47 129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
1710		tals Results record	+	1710			DATE
	information was						
		I system by the CNAs and					
		eted for every meal, so					
	_	-					
	that the resident's intake on any date could be tracked.						
	oc nacked.						
	The Vitals Resul	lts for weight was					
	provided by the						
	^	1/14/12 at 4:20 p.m. The					
		the resident's weight on					
		/14/12 was 152 pounds, a					
		n 10/16/12 was 152					
		utine weight on 11/3/12					
	was 145 pounds.						
	was i is pounds.	•					
	The Vitals Resul	Its for 10/31/12 through					
		ed the resident was					
	· · · · · · · · · · · · · · · · · · ·	er on night shift on 10/31,					
		3/12. Progress Notes and					
	· ·	dicated no other vital					
		ded for the resident from					
	~	1/7/12, when a Progress					
		m., indicated, "Called to					
		er. res noted to have very					
	1	rine noted on penis and in					
	<u>-</u>	ecrease in LOC [level of					
		out is still able to answer					
	1	nies pain states he doesn't					
	_	ooke to family r/t [related					
		inting res sent out					
	l	hat we could do stat					
		s and iv [intravenous]					
	-	ibiotics] or just abt if					
	_		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155697		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. NUNC (X3) DATE SUF COMPLETI 11/14/20			ETED		
		10007	B. WIN		DDDEGG CITY OT ATE TID CODE	1 17 1 - 47	2012
NAME OF P	ROVIDER OR SUPPLIEF	2			NDDRESS, CITY, STATE, ZIP CODE ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTE	R		SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
IAG		e fine with that having	+	TAG	DEFICIENCE!)		DATE
	_	v/s call out to md. [sic]"					
	Vitals Results at 2:30 p.m., indicated						
	_	2 degrees Fahrenheit;					
	•	nute; respirations: 18 per					
	minute; blood pr	ressure: 60/40.					
	A Progress Note	for 11/7/12 at 2:13 p.m.,					
	indicated the family insisted the resident						
	be transferred to the hospital.						
	•	tory and Physical, dated					
	-	ed, "History of Present					
		l been discharged to Clark					
	_	Home. Relatives state					
		having poor oral intake,					
	•	et. He is not drinking and					
	_	en elevated at 700 with					
		oility and increasing in the sacral area.					
		o check on his decubitus					
	_	and she has found that he					
	, ,	narge coming from his					
		materialReview of					
		talia: Scrotum mildly					
	-	He has on the skin					
	*	stage 4" The Plan					
		ident would receive bolus					
		ds, admission to the					
		nit, and "will consult					
		n] to assist his decubitus					
	ulcer"	-					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/28/2012 FORM APPROVED OMB NO. 0938-0391

I 155607	B. WING	00	COMPLETED 11/14/2012			
NAME OF PROVIDER OR SUPPLIER CLARK REHABILITATION AND SKILLED NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129					
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
3.1-40(a)(1) 3.1-40(a)(2)						

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Facility ID: 000059

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	л рин	DING	00	COMPL	ETED
		155697	A. BUILDING B. WING 11/14/2012			2012	
			b. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
CLARKE	ΡΕΗΔΒΙΙ ΙΤΔΤΙΩΝ Δ	ND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129				
			1		OVICE, IIV 47 123		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATI		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0514	483.75(I)(1)						
SS=D	RES	DI ETE/ACCUDATE/ACCE					
	RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on						
	•	accordance with accepted					
		dards and practices that					
		curately documented;					
	readily accessible	e; and systematically					
	organized.						
	The clinical record must contain sufficient						
		ntify the resident; a record					
		assessments; the plan of sprovided; the results of					
		n screening conducted by					
	the State; and pro	•					
	· · · · · · · · · · · · · · · · · · ·	review and interview, the	F05	14	What corrective action(s) will	I	11/28/2012
		ensure documentation in			be accomplished for those		
	•	d was complete and			residents found to have been	1	
		3 residents whose			affected by the deficient		
					practice?Resident A no long	er	
	records were rev				resides in the facilityResiden		
	documentation in	*			B has weekly skin assessments		
	(Residents A, B,	and C)			documented in the clinical		
					recordResident C was dischar	-	
	Findings include	::			to home How other residents having the potential to be	•	
	-				affected by the same deficier	nt	
	1 The clinical r	ecord for Resident A was			practice will be identified and		
		13/12 at 3:20 p.m. The			what corrective action(s) will		
		the resident was admitted			be taken?All residents have t		
					potential to be affected by the	е	
	•	1 on 10/14/12 and			alleged deficient		
	discharged to the	e hospital on 11/7/12.			practices. Licensed nurses		
					were inserviced on assessing	_	
	A. The hospital	History and Physical,			residents skin upon admissio	on	
	dated 11/8/12, in	idicated in "History of			and weekly by the wound		
	•	He has been discharged			nurse/designee post test		
		Nursing Home. Relatives			included on or before		
	w Clark Reliad I	nuising nome. Relatives			11/27/2012.Licensed nurse w	ill	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155697	B. WIN			11/14/2012
			р. wnv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	t .			ITTLE LEAGUE BLVD	
CLADKE	DELIADII ITATIONI A	ND SKILLED NURSING CENTER				
OLAINNI	ALI IABILITATION A	AND SKILLED NORSING CENTER		CLAIN	SVILLE, IN 47129	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	state that he has	been having poor oral			also be re-educated on	
	intake, not taking his diet. He is not				compliance report for meal	
	drinking"				consumptions and completing	_
					the transfer/discharge form b	
	The Vitals Resul	Its for the resident's stay			the SDC/designee on or befo (11/27/2012) post test	re
		dicated no documentation			included.Any wounds identif	ied
	_				on admission or weekly skin	lea
		ntake from 10/31 to			assessment will be measured	₁ .
		ollowing dates for meals			MD notified, treatment	
	as indicated: 10/	31/12: breakfast and			obtained, individual wound	
	supper undocumented; 11/1/12: breakfast and lunch undocumented; 11/2/12:				sheet completed, care planne	ed
					and added to the weekly NAF	R
	dinner undocum	ented; 11/3/12: dinner			(Nutrition at Risk)review by t	he
	undocumented;				charge nurse/unit manager.	
	undocumented;				Any residents presently	
		and 11/7/12: breakfast			reviewed in the NAR meeting	
		and 11///12. Dieakiast			have been audited to ensure	
	undocumented.				weights and meal	
					consumptions are document accurately by the	ea
	During interview	v on 11/14/12 at 4:05			DNS/designee Licensed nurs	96
	p.m., the facility	's Nurse Consultant and			will run the compliance report	
	Assistant Directo	or of Nursing (ADON)			at the end of their shift to	`
	indicated the Vit	als Results record should			ensure meal documentation	is
		r every meal, so that the			complete-any ommissions	
	•	on any date could be			identified will be relayed to the	ne
	tracked.	on any dute could be			c.n.a. to complete prior to the	
	u ackeu.				end of their shift.Any residen	
	D 001 121 1 5	1. 6			with a transfer/discharge will	
	B. The Vitals R	•			be reviewed daily by the	
		ident's weight on			IDT/Unit Manager to ensure	
	admission on 10	/14/12 was 152 pounds, a			form completed and includes	
	routine weight o	n 10/16/12 was 152			resident name, date, address that resident was transfered	
	pounds, and a ro	utine weight on 11/3/12			discharged to, City, State and	
	was 145 pounds.	_			zip code.Non-compliance wit	
	r.o pounds.	•			these practices will result in	
	A Drogragg Mata	arouted by the Distory			further education including	
	_	created by the Dietary			disciplinary action.Wound	
	Manager on 10/3	31/12 at 5:54 p.m.,	1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SU	RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ED	
		155697	B. WIN			11/14/20)12
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹	517 N LITTLE LEAGUE BLVD				
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	1	CLARK	(SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated, "Current wt. [weight] is 148#				nurse and DNS/designee is		
	[pounds], down 1# since admission"				responsible for complianceWhat measures	will	
					be put into place or what	WIII	
	During interviev	v on 11/14/12 at 4:20			systemic changes will be m	ade	
	p.m., the facility	's Nurse Consultant			to ensure that the deficient		
	indicated she did	d not know where the			practice does not		
	weight of 148 po	ounds came from. She			recur? Licensed nurses we	re	
		ondered if the Dietary			inserviced on assessing		
		d the weight of 145			residents skin upon admiss	sion	
	_	realized that weight was			and weekly by the wound nurse/designee post test		
	measured after the Dietary Manager's				included on or before		
	Progress Note.	ne Dietary Manager s			11/27/2012.Licensed nurse	will	
	Progress Note.				also be re-educated on		
	0 Trl 1: 1	1.C. D. :1. (D.			compliance report for meal		
		record for Resident B was			consumptions and complet	ing	
		13/12 at 11:30 a.m. The			the transfer/discharge form	-	
		oses included, but were			the SDC/designee on or bef	ore	
	not limited to, a	chronic diabetic ulcer to			(11/27/2012) post test	ified	
	the right foot/and	kle.			included.Any wounds ident on admission or weekly ski		
					assessment will be measure		
	Skin Integrity E	vent reports for the wound			MD notified, treatment	, 	
	were reviewed f	or 8/1/12 through the			obtained, individual wound		
	resident's discha	rge on 9/23/12. Skin			sheet completed, care plant	ned	
	Integrity Events	were completed weekly			and added to the weekly NA	\R	
		12 through 9/23/12.			(Nutrition at Risk)review by	the	
					charge nurse/unit		
	During interview	v on 11/14/12 at 12:45			manager. Any residents presently reviewe	nd in	
	_	's Nurse Consultant			the NAR meeting have been		
		vas no weekly Skin			audited to ensure weights a		
		•			meal consumptions are		
		for the 10 days prior to the			documented accurately by	the	
		rge on 9/23/12. The			DNS/designee The wound		
		nt indicated the Assistant			nurse/designee will conduc		
	Director of Nurs	_			chart audits weekly to ensu	re	
		nd information about the			skin assessments are completed.Licensed nurses		
	resident's wound	l on her "composite sheet"	1		completed.Licensed nurses	•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ED	
		155697	A. BUII B. WIN			11/14/20)12
		<u> </u>	b. why		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			LITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER			(SVILLE, IN 47129		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE (COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	on which she tracked all wounds in the				will run the compliance repo	rt	
	facility.				at the end of their shift to		
	J				ensure meal documentation	is	
	On 11/14/12 at 4	4:30 p.m., the Assistant			complete-any ommissions		
	Director of Nurs	-			identified will be relayed to t		
		0.1			c.n.a. to complete prior to th		
	1	cating the measurements			end of their shift.Any resider with a transfer/discharge wil	I	
	^	of the resident's wound on			be reviewed daily by the	'	
	9/12/12. The in	nformation was not			IDT/Unit Manager to ensure		
	included in the o	clinical record.			form completed and includes	s	
					resident name, date, address		
	3. The clinical record for Resident C was reviewed on 11/13/12 at 12:00 p.m. The				that resident was transfered		
					discharged to, City, State an	d	
		the resident was admitted			zip code.Non-compliance wi	th	
					these practices will result in		
	-	9/16/12 following total			further education including		
	knee replacemen	nt.			disciplinary action.Wound		
					nurse and DNS/designee is		
	A. The Admission	on/Readmission - ASC			responsible for		
	(American Senio	or Communities) Nursing			compliance How the correct		
	Admission Asse	essment, dated 9/16/12,			action(s) will be maintained to ensure the deficient practice		
	indicated, "Skin	Conditions			will not recur, i.e., what quali	I	
	· ·	urgical Incision - R [right]			assurance program will be p		
		high to right below knee."			into place? The CQI audits for		
		notation indicated, "If			skin management,		
					transfer/discharge, and food, f	fluid	
		egrity alteration (wound			intake and weight records will		
	· · · · · · · · · · · · · · · · · · ·	are noted on admission			utilized weekly x4, monthly x6		
		ea and complete a skin			quarterly thereafter. Findings for		
	sheet for each ar	rea." A skin sheet related			the CQI process will be review monthly and an action plan wi		
	to the wound wa	as not indicated in the			implemeted as needed for any		
	clinical record.				deficient practices below the 9		
					threshold.Wound nurse and D		
	During interview	v on 11/14/12 at 12:40			designee is responsible to ens	sure	
	_	ant Director of Nursing			compliance		
	-	_					
		was no skin sheet for the					
	surgical wound.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155697	B. WIN	G		11/14/	2012
NAME OF P	ROVIDER OR SUPPLIER	· {	•		ADDRESS, CITY, STATE, ZIP CODE	_	
					ITTLE LEAGUE BLVD		
CLARK F	REHABILITATION A	AND SKILLED NURSING CENTER	₹	CLARK	SVILLE, IN 47129		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION
IAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		44					
		ge/Appointment/Transfer					
		Skilled Nursing Center					
		ident Transfer Form, dated					
	_	p.m., indicated, "Res has					
		/28/12. C/O [complaint					
	of] dizziness an	d weakness. Family					
	requests transfer	to [name of local					
	hospital]VS [vital signs] WNL [within normal limits]."						
	The Notice of T	ransfer and Discharge					
	form related to t	he discharge on 9/29/12,					
	filed in the Misc	cellaneous tab of the					
	record, failed to	include complete					
		ted to the following:					
		Date Issued, the Transfer					
		fective Date (month, date,					
	_	or Discharge to Address					
	(number and stre	_					
	`	rge to City, State, ZIP					
		ctions of the form were					
		ctions of the form were					
	left blank.						
	2.1.50(-)(1)						
	3.1-50(a)(1)						
	3.1-50(a)(2)						

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